

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

16849

1. PLACE OF DEATH

County New Madrid
Township _____
City St. No. _____ (No. _____)

Registration District No. 604
Primary Registration District No. 5202

File No. 47
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Morris Deane Fleming

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) ✓

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/6/30

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New Madrid
(STATE OR COUNTRY) County

10. NAME OF FATHER George Fleming

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Alabama
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lena Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

14. INFORMANT J. D. Cole
(Address) New Madrid, Mo

15. FILED 5/25 1930 M. J. Shannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/25 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dead without medical attention. Probably Bronch. Pneumonia

(duration) yrs. mos. ds. 10 1/2 hrs
CONTRIBUTORY (SECONDARY) Muscle

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? M. J. Shannon M. D.
(Signed) _____

, 19 (Address) St. Louis, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Evergreen Cemetery DATE OF BURIAL 5/25 1930

20. UNDERTAKER Richard Ward Co. ADDRESS New Madrid Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH - DEPARTMENT RECORD

